STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #30525 and #31214 were completed on March 18-21, 2013, at Center on Aging and Health. No deficiencies were cited related to complaint investigation #30525 and #31214, under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F 156 483.10(b)(5)-(10),483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 1) Starting on 3/13/2103 an ABN will be sent to all residents affected by deficient practice. 2) The Admissions Coordinator and Staff Surveyor reviewed all residents requiring ABNs and sent them out. 3) The Admissions Coordinator and Staff Surveyor developed the proper form needed and will attend the weekly meeting with therapy to identify which residents require an ABN. 4) The Admissions Coordinator will report to QA with log of residents requiring ABNs (done on a quarterly basis). QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	3/15/13 4/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5/16/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F 156 483.10(b)(5)-(10),483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES Residents #84, #90, & #102 1) ABNs have been sent to residents #84, #90 & #102 2) All residents/POA receiving skilled services will be provided an ABN prior to the end of their skilled services. Compliance achieved at survey end on March 21, 2013. 3) A log will be maintained in the Admissions Office and there will be a weekly meeting conducted. 4) ABN log along with minutes of weekly meeting will be presented during the quarterly QA meetings for a period of one year. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	4/18/13

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to notify three residents (#84, #90, & #102) in a timely manner (no later than 2 days) of appeal rights of skilled services being termination. The findings included: Review of Liability Notices and Resident Appeal Rights (Advance Beneficiary Notice (ABNs) of three residents #84, #90, & #102, revealed no documentation the residents or their legal representative were notified of appeal rights at least two days prior to termination of skilled services. Interview with the Admission Coordinator, in the Admission office, on March 20, 2013, at 3:00 p.m., confirmed the facility haad failed to insure the residents or residents' representives were notified timely of appeal rights for termination of skilled services for resident #84, #90, and #102.	F 156		
F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF	F 159	F 159 483.10 (c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS	

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F 159 SS=D	Continued From page 3 PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	Resident #57 1) The quarterly financial statements on resident #57 for October-December 2012 were reviewed and sent out on January 4, 2013. The resident trust funds for the first quarter of 2013 (January-March 2013) were sent out on April 4, 2013. 2) All residents with trust accounts have been sent statements of their trust funds with balances by the Office Manager. 3) All residents will have a copy of their quarterly financial statements of their trust account and will sign an acknowledgement of said account to keep on file. A letter will be sent to the POA's for residents with dementia or those who cannot sign for themselves with a self stamped envelope to send the letter back to us once signed. This letter is acknowledgement of the resident's trust funds as well as a copy of their quarterly statements. An Excel Spreadsheet implemented for monitoring. 4) The Office Manager will present an Excel spreadsheet of all residents and their trust funds quarterly for three quarters to the QA Committee. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	4/4/13 4/8/13 4/18/13

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F 159	Continued From page 4 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of the trust fund accounts and interview the facility failed to provide quarterly statements to one resident (#57) of thirty-eight residents reviewed. The findings included: Interview with resident #57 on March 19, 2013, at 10:45 a.m., in the resident's room, revealed the resident had a personal fund account the facility managed and the facility did not provide quarterly statements to the residents with personal funds. Interview with the office manager on March 21, 2013, at 12:47 p.m., confirmed the facility was not sending out quarterly statements when the office manager started in November 2012.	F 159		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	F 221	F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINT Resident #109 1) Will be monitored and redirected by staff frequently. Staff will be educated on the importance of maintaining the privacy of other residents. Verbal Consent given for use of restraint on January 18, 2013. Family has	

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F 221	Continued From page 5 by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess for a restraint for one (#109) of thirty-eight residents reviewed. The findings included: Resident #109 was admitted to the facility on April 13, 2010, with diagnoses including Fracture of Femur, Vascular Dementia with Depressed Mood, Anxiety, Anemia, and Hypertension. Medical record review of the quarterly Minimum Data Set dated January 23, 2013, revealed the resident had severe cognitive impairment with behaviors of wandering requiring supervision. Medical record review of Physical Therapy notes revealed the resident received Occupational and Physical Therapy for a fractured femur until October 1, 2012, when the resident was discharged to Restorative Nursing due to the resident had reached maximum potential. Further review revealed the resident ambulated with assistance or by pushing a wheelchair instead of using a walker. Review of the Rehabilitation/Restorative Service Delivery Record dated October 12, 2012, revealed, "Resident was d/c (discharged) from w/c (wheelchair) and placed in meri-walker (restraint)." Medical record review revealed no documentation a consent was obtained by the resident's representative prior to application of a restraint; no documentation a pre-restraint assessment had	F 221	signed a written consent. Pre-restraint Assessment Order dated 1/18/2013 was unavailable at the time of survey. First evaluation was done on 1/18/13 and the consent form had been signed. 2) Known wanderers will be monitored and redirected more frequently to ensure that they remain within their allowed boundaries effective 3/19/13. Educate the staff to be on alert of wandering residents at all times. All residents with restraints will have pre-restraint assessments completed. Pre-restraint assessment is to be completed on any resident that has a need to be in any type of restraint. A consent by the POA and assure MD order are obtained prior to the use of the restraint as well as yearly to continue the use of the restraint. Compliance will be adhered to by 5/5/13. 3) Ongoing education of staff will be completed periodically to ensure that they are monitoring the residents effectively. In-service form implemented to monitor compliance. A reassessment will be done monthly . A physician's order will be obtained in order to place a restraint on a resident. The restraint will be assessed monthly for appropriateness and for possible reduction. Documentation for the use of a restraint will include: the type of restraint device, the reason for application, and any alternative methods used and their outcome. A care plan meeting will be initiated for the resident in regards	4/18/13 Safety Mtg 5/5/13

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F 221	Continued From page 6 been completed prior to applying the restraint; no documentation of a least restrictive restraint being attempted; and no documentation a physician's order was obtained for the restraint prior to application. Review of facility policy Restraints, revealed, "...Assess the resident for need and type of restraint, contact family about the risk and benefits of using restraints, and update the Care Plan...Obtain physician's order-specifying type of restraint and reason for use...The restraint will be assessed on a quarterly basis...Documentation of the use of restraints will include type of device, reason for application, and any alternatives used and the outcome." Observation on March 21, 2013, at 8:00 a.m., revealed the resident in a merlwalker ambulating (wandering) on the East and North hall. Interview with Restorative Nursing Assistant (RNA) #1, in the restorative office, on March 20, 2013, at 2:00 p.m., revealed if a restraint was to be attempted, therapy was to be notified to evaluate and obtain a physician's order. Further interview confirmed the CNA was unaware if therapy evaluated the resident prior to placing the resident in the restraint. Interview with the Occupational Therapist, in the therapy room, on March 20, 2013, at 2:30 p.m., confirmed the resident had not been assessed by therapy prior to placing the resident in the merlwalker. Interview with the Registered Nurse Supervisor in the Director of Nursing's office on March 20,	F 221	to the use of a restraint. 4) A tracking log will be kept and reviewed quarterly at the monthly safety meeting which will consist of the Administrator, Safety Director, QA Nurse, DON, ADON, Restorative Staff Member, Rehab Director and the Activities Director. Minutes of Safety Meetings, Log of Consent, Assessments, and MD Order will be presented during the quarterly QA meetings. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	4/18/13

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F 221	Continued From page 7 2013, at 1:45 p.m., confirmed at the time the resident was placed in the meri-walker in October 2012, the resident had not been assessed for the device, no pre-evaluation had been completed, no consent had been signed, and no physician order had been obtained.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote dignity during an activity in the secure unit for three residents (#56, #75, #81) of thirty-eight residents reviewed. The findings included: Observation on March 20, 2013, from 9:12 a.m. through 9:48 a.m., in the secure unit day area, revealed three residents asleep during an activity. Interview on March 20, 2013, at 9:59 a.m., in the secure unit day area, with Certified Nursing Assistant #1 and #2, confirmed the three residents were asleep and the facility failed to promote dignity by leaving the residents in the activity while asleep.	F 241	F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1) Activity Assistant was trying to keep residents #56, #75, & #81 aroused to participate in activity but they were not removed from the activity while dozing. 2) If medications are due at the same time as an activity the resident will be taken back to their room and then returned to complete the activity. Monitor mealtimes/activities for residents who are sleeping and assist those removed back to their rooms. Compliance mandated by 5/5/13. 3) Assess the activity levels of each resident and remind staff that residents cannot sleep during any mealtime or activity to maintain their dignity. Activity log to be implemented and maintained. The Activities Director to initiate an activity log which will document the residents inability to participate in activities or scheduled mealtimes. 4) The log will be reviewed at QA meetings on a quarterly basis. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		ONGOING

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F 252	Continued From page 8 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, the facility failed to provide a homelike environment during resident showers for one of three wings; during dining for nine of thirty-five residents during two of two dining observations; and for the day room on one of two wings. The findings included: Observation of the west wing central shower on March 20, 2013, at 9:10 a.m., revealed the residents lined up in wheelchairs outside of the shower room on the west wing hall waiting to be showered. Upon entering the shower room, observation revealed four residents in the room, two (#74, #80) in individual shower stalls behind privacy curtains and two waiting to be showered behind and facing a privacy curtain. Country music was playing on a radio. Resident #35 was asleep while waiting in the room to be showered and resident #148 was staring at the curtain while waiting to be showered. As residents #74 and #80 were removed from the shower room, residents #35 and #148 were moved into the individual private showers. Residents #74 and #80 were taken out of the shower room and two more residents were taken into the shower room to be placed in the "waiting" position as resident #35 and #148 were showered.	F 252	F252 483.15(h)(1) SAFE/CLEAN/ COMFORTABLE/HOMELIKE ENVIRONMENT 1) All residents are now being surveyed of their preference of whether their plate is left on or off of the tray at all mealtimes. 2) Staff is to monitor the residents prior to meal times to ensure that the resident has preference of their tray. To be implemented by 5/5/13. 3) Survey log has been implemented by the Dietary Manager to monitor resident's preference to whether they want the plate on or off of their tray. Dietary Manager will review results and follow preferences based on survey. 4) Survey log to be reviewed by Dietary Manager with QA Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F252 483.15(h)(1) SAFE/CLEAN/ COMFORTABLE/HOMELIKE ENVIRONMENT Residents #35 & #148 1)To be encouraged to remain in their rooms until their designated shower times or until a staff member transports them to the shower rooms. 2) The shower schedule is to be reviewed on a daily basis and staff is to remind the residents of their assigned shower times. Compliance to be met by 5/5/13. 3) CNA Mentor member will monitor the daily	4/15/13 5/5/13

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F 252	Continued From page 9 Interview with resident #148 on March 20, 2013, at 3:00 p.m., in the hallway outside the resident room, revealed the resident expressed no problem with the way residents wait in the shower room and stated "we are used to it." Interview with resident #151 on March 21, 2013, at 10:00 a.m., in the resident room, revealed no problems with the way showers are given, "it takes less time and they give good showers." Interview with the Director of Nursing (DON) and Certified Nursing Assistant (CNA) #4 on March 21, 2013, at 9:50 a.m., in the shower room, confirmed showers are given to two residents while two other residents wait behind the curtain. Further interview with the DON confirmed the showering system was an institutional type environment and not homelike. Observation on March 19, 2013, at 11:50 a.m., in the main dining room, revealed twenty-nine residents in the dining room for lunch. Observation revealed lunch was served on the tray and the plates were not removed to the table top. Observation on March 20, 2013, at 7:59 a.m., in the main dining room, revealed twenty-eight residents eating breakfast, all residents' plates were on the tray and had not been moved to the table top. Interview with CNA #2 and CNA #3 on March 20, 2013, at 8:15 a.m., in the dining room, revealed "used to remove the plates from the trays and the residents were spilling the plates in their laps	F 252	shower room schedule. Staff will transport residents to the shower room at their designated shower times. 4) QI will be reviewed quarterly at the QA meeting. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F252 483.15(h)(1) SAFE/CLEAN/ COMFORTABLE/HOMELIKE ENVIRONMENT 1) The facility and staff will strive for a more homelike environment while also monitoring residents closely who may be sleeping. Any residents sleeping while waiting for their shower will be taken back to their room and showered at a later time. 2) Any residents who are sleeping and/or drowsy will be taken back to their rooms. Compliance was started 3/22/13. Residents will have a variety of magazines to read while waiting for their shower. Residents will also be given a choice of whether or not they want to listen to music while they baths and what type of music they prefer. By offering a variety of options we are attempting to create a more homelike environment. 3) Excel spreadsheet created to ascertain majority of residents' preference of music while waiting for showers. 4) Monitoring tool implemented and completed by CNA Mentor or designated staff presented	5/5/13

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F 252	Continued From page 10 because the plates were sliding on the glass top, the residents complained and wanted the plates left on the trays." Further interview revealed they were not sure if the matter was discussed in resident council or not but "the ok came from somewhere for us to leave the plates on the trays" so we were trying this for a while. Review of facility documentation revealed on March 20, 2013, the Dietary Manager did a survey of the lunch residents in the dining room regarding leaving the plates on the trays. Thirty-five residents voted, twenty-six requested to have plates left on the tray. Interview with the Dietary Manager on March 21, 2013, at 2:45 p.m., in the dining room, confirmed had not thought about the preferences of those nine residents who wanted the plates removed from the trays, only the ones who wanted the plates left. Observation on initial tour March 18, 2013, at 7:20 p.m., revealed the day room on the east wing unlocked and a patient lift stored in the room. Observation revealed the lift had dirt and grime on the foot rests. Also stored in the room were Christmas decorations and Valentine decorations in boxes on a long table. Interview with Licensed Practical Nurse (LPN) #9, CNA #11 and CNA #12 on March 20, 2013, at 3:00 p.m., in the day room, confirmed the lift was usually stored in the day room, which was not where it was to be stored, and the foot rest was dirty. Further interview confirmed the Christmas and Valentine decorations were from another room and were not to be in the day room. Further	F 252	at the quarterly QA Meeting . The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F252 483.15(h)(1) SAFE/CLEAN/ COMFORTABLE/HOMELIKE ENVIRONMENT 1) The resident lift has been properly cleaned and stored in designated areas. One to be kept in the brief room and the other to be kept next to the weight scales on West Wing. 2) CNA Mentor to in-serviced on proper storage and cleaning of resident lifts on 5/2 & 5/3/2013. Compliance met on 3/22/13. 3) Check off implemented and to be monitored by Safety Director and Maintenance every month.	5/5/13

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	445424	A. BUILDING _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 252	Continued From page 11 interview confirmed residents used the day room for daily activities.	F 252	4) Check off sheet will be submitted to the QA Committee during the quarterly meeting. QA consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide maintenance services for two wheelchairs out of twenty two wheelchairs observed, for one privacy curtain, for two bed side rails out of thirty-two siderails observed, and for two of four central showers observed. The findings included: Observation of a wheelchair in use by resident #39 on March 21, 2013, at 1:40 p.m., in the west activity room, revealed worn duct tape on the foot pedals. Continued observation of a wheelchair in use by resident #102, on March 21, 2013, at 1:45 p.m., in the main dining room revealed duct tape on bilateral foot rest support bars. Observation on March 21, 2013, at 1:48 p.m., in room 245, revealed foam pipe insulation covering the bilateral quarter rails of bed A, with duct tape wrapped around it. Interview with Licensed Practical Nurse #8, on March 21, 2013, at 1:50 p.m., confirmed the presence of the duct tape on the wheelchairs and pipe insulation on the bedrails.	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1) Duct tape was removed from the bilateral quarter rails on bed A in room 216. The East Wing shower curtain has been repaired. The privacy curtain in room 216 has been fixed. 2) All wheelchairs, bed rails, and shower room equipment will be inspected to ensure safety and cleanliness. All equipment will be free of duct tape. Staff will be informed that duct tape on wheelchairs, bed rails, and other facility equipment is unacceptable. Compliance met 3/22/13. 3) Wheelchairs, bed rails and privacy curtains will be inspected regularly by maintenance and upon request for service. 4) Maintenance will maintain a log to track cleanliness and list repairs needed on wheelchairs, bed rails and privacy curtains. This log will be reviewed with the QA Committee until maintenance compliance is acknowledged. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

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F 253	Continued From page 12 Observation of the west wing central shower on March 20, 2013, at 9:10 a.m., and on on March 21, 2013, at 9:50 a.m., revealed paint peeling off the ceiling in one of two shower stalls and the light cover was held closed over the light with a zip tie for one of two shower stalls. Interview with the Director of Nursing on March 21, 2013, at 9:50 a.m., in the central shower, confirmed the ceiling and light was in need of maintenance services. Observation and interview with the Purchasing Manager on March 21, 2013, at 2:38 p.m., confirmed room 216's privacy curtain was not operational.	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1) The West Wing central shower ceiling has been painted. The zip-tie has been removed from the light cover and has been fixed appropriately. 2) There will be routine maintenance checks on all shower rooms, walls, ceilings and light fixtures monthly. Checks will begin 5/5/13. 3) The shower rooms are to be inspected quarterly by maintenance and logged into a tracking log specifically for the shower rooms. 4) Maintenance will submit the tracking log to QA meetings ongoing. QA consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 13 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to conduct a comprehensive assessment for one (#90) of four residents reviewed for use of restraints and for two (#151 and #39) of three residents reviewed for urinary catheters of thirty-eight sampled residents. The findings included: Resident #90 was admitted on December 6, 2012, with diagnoses of Polyarthralgia, Hypertension, Congestive Heart Failure, History of Falls, Leukocytosis, Rhabdomyolysis, and Atrial Fibrillation.	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1) Verbal consent given for use of restraint on Resident #90. Family has a written consent. 2) All residents with restraints will be evaluated that a pre-restraint assessment has been completed. Pre-Restraint Assessment is to be completed on any resident that has a need to be in any type of restraint. A consent by the POA must be obtained initially prior to the use of the restraint as well as yearly to continue the use of the restraint. This will be in compliance by 5/5/13.	5/1/13

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F 272	Continued From page 14 Observation of the resident on March 20, 2013, in the resident's room, revealed the resident sitting in a wheelchair with a lap buddy (a restraining cushion placed on the resident's lap to prevent the resident from falling out of the wheelchair) in place. Medical record review revealed two Physical Therapy notes, dated February 18, 2013 and February 25, 2013, addressing the lap buddy in the resident's wheelchair. Continued medical record review revealed there was no comprehensive pre-restraint assessment until March 15, 2013. Review of facility restraint policy with a completed date of August 6, 2012, revealed the facility's policy was to assess the resident for need and type of restraint, contact family about the risk and benefits of using restraints, and update the Care Plan. Observation and interview with Licensed Practical Nurse # 10, on March 20, 2013, at 9:08 a.m., in the resident's room, confirmed the resident could not remove the lap buddy without assistance. Interview with the Director of Nursing (DON) on March 21, 2013, at 8:36 a.m., in the DON's office, confirmed the lap buddy had been placed on the resident before the required pre-restraint assessment. Resident #151 was admitted to the facility on February 8, 2013, with diagnoses including Muscle Weakness, Pneumonia, Chronic Airway Obstruction, and Paralysis Agitans.	F 272	3) A reassessment will be done monthly. A physician's order must be obtained in order to place a restraint on a resident. The restraint will be assessed monthly for appropriateness and for possible reduction. Documentation for the use of a restraint will include: the type of restraint device, the reason for application, and any alternative methods used and their outcome. A care plan meeting will be initiated for the resident in regards to the use of a restraint. Safety meetings will be conducted monthly to review the condition of the residents and possible reduction of restraint use. The next safety meeting will be on May 1, 2013. 4) A tracking log will be presented by the Safety Director with the meeting minutes from the safety meeting along with a list of restraint reduction attempts to the QA Committee on a quarterly basis for a period of one year. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	6/1/13 8/1/13

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F 272	Continued From page 15 Medical record review of a Progress Note dated February 13, 2013, revealed "...Quality indicators...Indwelling catheter...may place foley cath (indwelling catheter) while trying to heal perineum. Cath should be removed as soon as area heals..." Medical record review of the admission Minimum Data Set (MDS) dated February 14, 2013, revealed the Brief Interview for Mental Status (BIMS) score was fifteen (no cognitive impairment), had a diagnosis of neurogenic bladder and had an indwelling catheter. Medical record review of the Care Plan with problem date and review date of February 28, 2013, revealed "...altered urinary function: Foley catheter in use...related to neurogenic bladder and perineal excoriation..." Medical record review revealed no documentation of a diagnosis of neurogenic bladder. Interview with the resident in the resident's room on March 19, 2013, at 9:40 a.m., revealed the catheter was inserted soon after admission and the resident was not informed why it was needed or for how long it would be in. Continued interview with resident revealed the catheter had occasional "leakage" in the past, but was able to toilet and did not have any issues with urge to urinate or incontinence. Interview on March 21, 2013, at 10:00 a.m., with the resident in the resident's room, revealed the resident mentioned the catheter to the nurse yesterday and the catheter was removed, the	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1) MDS assessments and diagnoses for residents #151, #39 & # 90 have been corrected to reflect accurate RAI's and restraints. 2) A review of all residents RAIs to be conducted by the MDS Coordinator and updated for any potential deficiencies. Compliance to be met by 5/5/13. 3) An audit tool will be developed and conducted by the QA Nurse monthly on 10% of all residents by 5/5/13. 4) The audit log will detect potential deficiencies, be tracked, and reported in the quarterly QA meeting. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

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F 272	Continued From page 16 resident had "gone to the bathroom" twice since then, and was glad to have it out. Interview with Licensed Practical Nurse (LPN) #4, who was the MDS reviewer, on March 21, 2013, at 1:00 p.m., outside the Director of Nursing (DON) office, confirmed the resident did not have a diagnosis of neurogenic bladder, and the MDS assessment was inaccurate. Resident #39 was admitted to the facility on January 30, 2013, with diagnoses including Insomnia, Constipation, Dementia, Nervousness, Anxiety, Agitation, Hypertension, Hallucination, Cystic Fibrosis, Amnesia, Gastritis, Vitamin B Deficiency, and History of Myocardial Infarction.. Medical record review of a significant change MDS dated February 2, 2013, revealed the MDS was not coded for an indwelling catheter and was coded for "frequently incontinent" for urinary incontinence. Observations of the resident on March 19, 2013, at 10:00 a.m., and 3:15 p.m., on March 20, 2013, at 9:00 a.m., and 2:00 p.m., and on March 21, 2013, at 7:55 a.m., revealed the resident was sitting in a rock and go chair in the hall or the resident room with an indwelling catheter in place. Interview with the LPN #4 (MDS reviewer) on March 21, 2013, at 1:00 p.m., outside the Director of Nursing (DON) office, confirmed the MDS was inaccurate.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279	F 279 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS 1) Resident #109 and #79 care plan have been	

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F 279	Continued From page 17 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan for a behavior of wandering for one (#109) resident and for community discharge for one (#79) of thirty-eight sampled residents. The findings included: Resident #109 was admitted to the facility on April 13, 2010, with diagnoses including Fracture of Femur, Vascular Dementia with Depressed Mood, Anxiety, Anemia, and Hypertension. Review of the quarterly Minimum Data Set dated January 23, 2013, revealed the resident had	F 279	updated and reviewed by Social Services. 2) Will review and update all residents behavioral care plans by Social Services by May 5, 2013. 3) The MDS Audit/Care Plan for 10% of the population monthly will be reviewed by the Interdisciplinary team. Audit log initiated. 4) An audit log for tracking and reporting deficiencies will be kept and reported quarterly in the QA Meeting. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

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F 279	Continued From page 18 severe cognitive impairment and behaviors of wandering requiring supervision. Medical record review of the Care Plan last updated on January 30, 2013, revealed the problem of the wandering behavior had not been addressed and no interventions were in place. Observation on March 21, 2013, at 8:00 a.m., revealed the resident ambulating/wandering around the West nursing station and up and down the hallways. Further observation revealed the resident wandering in and out of residents rooms. Continued observation for twenty minutes revealed the resident had wandered into six different resident rooms and multiple times in several of the rooms. Interview with the Minimum Data Coordinators (MDS) /Care Plan Coordinators (#1, #2) in the MDS office on March 21, 2013, at 9:00 a.m., confirmed the behavior of wandering had not been care planned with interventions put in place. Resident # 79 was admitted to the facility on December 31, 2012, with diagnoses of Hypertension, Hyperlipidemia, Cerebrovascular Incident, Anxiety Disorder, Depression, and Chronic Obstructive Pulmonary Disease. Medical record review revealed no comprehensive care plan for community discharge in the resident's chart. Medical record review of a Social Services Note on admission stated "...uncertain if resident will be discharged home..." Interview with the Assistant Director of Nursing on	F 279		

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F 279	Continued From page 19 March 21, 2013, at 9:10 a.m., in the Director of Nursing's office, confirmed there was no discharge care plan initiated.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the resident's comprehensive care plan for nutrition for one (#79) and for restraints for one resident (#39) of thirty eight residents reviewed. The finding included:	F 280	F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN 1) Resident #39 and #79 Comprehensive Care Plans have been reviewed and updated to reflect the nutritional status and safety needs reviewed for the use of restraint device. 2) All Comprehensive Care Plans to be reviewed by MDS to ensure that the nutritional and safety needs are being met by 5/5/2013. 3) The MDS Coordinator will initiate the MDS Audit/Care Plan tool and review it monthly. 4)MDS/AUDIT/CAREPLAN Tool to be presented in the QA Meeting to ensure that the care plans are being updated. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

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F 280	Continued From page 20 Resident # 79 was admitted to the facility on December 31, 2012, with diagnoses of Hypertension, Hyperlipidemia, Cerebrovascular Incident, Anxiety Disorder, Depression, and Chronic Obstructive Pulmonary Disease. Medical record review of the Dietary Notes revealed the resident had a significant weight loss of ten percent, with a recorded weight of 100.2 pounds on January 6, 2013, and a weight of 87.6 pounds on February 12, 2013. Continued medical record review revealed the Registered Dietician (RD) had implemented interventions of med pass (a high calorie nutritional supplement) four ounces three times per day, Benecal (a nutritional supplement) with meals, and Remeron, an appetite stimulant. Medical record review of the Care Plan revealed the nutritional interventions had not been initiated by RD. Interview with the Assistant Director of Nursing on March 21, 2013, at 9:10 a.m., in the Director of Nursing's office, confirmed the care plan was not updated to reflect the nutritional interventions. Resident #39 was admitted to the facility on January 30, 2013, with diagnoses including Insomnia, Constipation, Dementia, Nervousness, Anxiety, Agitation, Hypertension, Hallucination, Cystic Fibrosis, Amnesia, Gastritis, Vitamin B Deficiency, and History of Myocardial Infarction. Medical record review revealed a Resident Care Conference was held on February 6, 2013, to update the care plan. Medical record review of the care plan revealed a review date of February	F 280		

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F 280	Continued From page 21 5, 2013 without update. Further review of the care plan revealed "...potential for injury...alarmed seatbelt in w/c...use...as ordered...alarmed seatbelt in w/c..." Observations on March 19, 2013, at 10:00 a.m., and 3:16 p.m., March 20, 2013, at 9:00 a.m., and 2:00 p.m., and March 21, 2013, at 7:55 a.m., and 12:05p.m., revealed the resident in a rock and roll wheelchair each time and no alarmed seatbelt in place. Interview with Certified Nursing Assistant (CNA) #7 on March 21, 2013, at 7:10 a.m., at the nursing station revealed the resident did not have an alarmed seatbelt in place. Interview with LPN #5 on March 21, 2013, at 10:15 a.m., at the nursing station, confirmed the resident did not have an alarming seatbelt and the care plan was not accurate.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and review of facility policy, review of manufacturer's instructions and interview, the facility failed to instruct a resident prior to use and failed to follow manufacturer's recommendations after use for use of inhalants for one (#110) of thirty-eight residents reviewed.	F 281	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1) Resident #110 has been educated on proper use of inhalants. LPN #1 was in-serviced by QA Nurse on proper administration of inhalant medications, and when indicated, the importance of rinsing the resident's mouth with water after inhaler use per manufacturer recommendations. 2) List will be obtained by pharmacy on all residents using inhalants and taught the administration on inhalant medications. Residents will be visually observed by QA Nurse with returned demonstration of usage of inhalers, and that the resident's are rinsing	4/30/13

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	445424	A. BUILDING _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	860 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 22 The findings included: Medical record review of the Physician's recapitulation orders for March 2013, revealed, "...Symbicort...160-4.5...inhale one puff by mouth..." Observation of the Licensed Practical Nurse (LPN) #1 in the resident's room on March 18, 2013, at 8:30 p.m., revealed LPN #1 administered the Symbicort and failed to give instruction on medication use prior to administration. Continued observation at this time revealed the resident took one quick puff without holding the breath and handed the Symbicort back to the LPN. Review of facility policy Metered Dose Inhaler Oral, revealed, "...4...c... instruct the resident to inhale through...mouth then depress the inhaler to release medication...d...Hold breath for 5-10 seconds for greater deposition of medication...g...Instruct resident to rinse mouth with water after inhaler use..." Review of the manufacturer's recommendations revealed, "...patient should rinse the mouth with water without swallowing..." Interview with LPN #1, at the 200 hall nurse's desk, on March 18, 2013, at 10:30 p.m., confirmed the facility policy and the manufacturer's recommendations were not followed.	F 281	his/her mouth out after the inhalant usage with water if indicated by 5/5/2013. 3) QA Nurse to in-service licensed staff on proper administration of inhalant drugs. Also, confirm that staff is properly educating the particular resident (if alert and oriented) on proper administration per Physician's orders and per manufacturer's recommendations. QI to be done quarterly by QA Nurse. (Changed from desk nurse to QA Nurse and monthly to quarterly as was noticed to be a mistake in dictation while revising the POC on 5/15/13)	5/5/13
			4) QI to be presented during the QA meeting. QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	4/18/13
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315	F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1) Resident #52's care plan was corrected by MDS to reveal that the resident is incontinent.	

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F 315	Continued From page 23 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Resident #52 was admitted to the facility on October 19, 2012, with diagnoses including Alzheimer's Disease with Dementia, Hypertension, Anxiety Disorder, and Delusional Disorder. Medical record review of the resident's Minimum Data Set (MDS) assessment dated October 26, 2012, revealed the resident was severely impaired cognitively, and required extensive staff assistance with ambulation, hygiene, and toileting. Continued MDS review revealed the resident was always continent of bowel and bladder, with staff assistance, and required no bowel or bladder program. Medical record review of the quarterly MDS assessment dated February 6, 2013, revealed the resident was frequently incontinent of bowel and bladder, and no toileting program had been implemented, when the decline was assessed. Medical record review of an Admission Care Plan date November 5, 2012, revealed incontinence had not been identified as an area of concern for the resident. Continued medical record review of	F 315	2) MDS Coordinator to review the MDS on all residents to ensure proper assessment and documentation of whether the resident continent vs incontinent by 5/5/13. 3) MDS to keep a QI on all residents to follow their bowel and bladder pattern and to also implement a bowel and bladder program. 4) QI to be reviewed and discussed at quarterly QA Meeting consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1) All residents with indwelling catheters assessed for medical justification. All residents with indwelling catheters have been secured to upper thigh to avoid tension on the catheter at all times. 2) The QA Nurse to review all residents with indwelling catheters to ensure they are justifiable and to ensure they are secured to the upper thigh to avoid tension on catheter by 5/5/2013. 3) The ADON to educate Nurses and CNAs of policy regarding securing indwelling catheters and also how to determine the ongoing need of the indwelling catheter by 5/5/2013.	5/5/13 4/18/13 5/5/13

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F 315	Continued From page 24 a re-admission Care Plan dated March 5, 2013, revealed the resident was incontinent, and required staff to offer toileting and provide incontinence care every two hours. Medical record review of Bowel and Bladder (B&B) Screens dated January 5, 2013 and March 5, 2013, revealed both screening tools identified the resident as a candidate for bowel and bladder retraining but no B&B program was initiated. Observation of the resident March 20, 2013, at 2:10 p.m., in the secure unit dayroom, revealed the resident participating in an activity. The resident was dressed and well groomed and wearing an incontinence brief per Certified Nursing Aid (CNA) # 1, assigned to the resident's care that day. Interview with CNA #1, on March 21, 2013, at 7:10 a.m., outside the resident's room, revealed the resident does wear incontinent briefs daily, and could respond to timed voiding schedules when prompted by staff. The CNA confirmed no formal continence program had been implemented for the resident. Interview with the Assistant Director of Nursing (ADON) on March 21, 2013, at 7:30 a.m., in the Director of Nursing's office, confirmed there had been a decline in bowel and bladder function for resident #52, and no interventions had been implemented by the facility to prevent that decline. Based on medical record review, review of facility	F 315	4) Implement a QI for security and ongoing need of all indwelling catheters. QI to be reviewed at quarterly QA Meeting consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	

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F 315	Continued From page 25 policy, observation, and interview, the facility failed to provide justification for an indwelling catheter and failed to remove a catheter timely for one resident (#151) and failed to follow facility policy for catheter care for two residents (#39 and #151) of three residents with catheters. The findings included: Resident #151 was admitted to the facility February 8, 2013, with diagnoses including Muscle weakness, Pneumonia, Chronic Airway Obstruction, and Paralysis Agitans. Medical record review of a Progress Note dated February 13, 2013, revealed "...Quality indicators...indwelling catheter...no briefs d/t (due to) perineal breakdown...may place foley cath (indwelling catheter) while trying to heal perineum. Cath should be removed as soon as area heals..." Medical record review of the admission Minimum Data Set (MDS) dated February 14, 2013, revealed the resident scored a 15 (no cognitive impairment) on the Brief Interview for Mental Status, was coded for neurogenic bladder and had an indwelling catheter. Medical record review of the Care Plan with problem date and review date of February 28, 2013, revealed "...altered urinary function: Foley catheter in use...related to neurogenic bladder and perineal excoriation...catheter care per facility protocol...potential for impaired skin integrity...occasional incontinence...pericare after each incontinence episode..."	F 315		

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F 315	Continued From page 26 Medical record review of a Bowel and Bladder Screen dated February 8, 2013, revealed score of 7 (candidate for toileting schedule [timed voiding] establish voiding patterns), and dated March 4, 2013, score of 8 (candidate for toileting schedule [timed voiding] establish voiding patterns). Observations of the resident on March 19, 2013, at 9:40a.m., and March 20, 2013, at 10:00 a.m., in the resident's room revealed the resident had an indwelling catheter and the tubing was not secured to the leg. Review of facility policy, Care of Indwelling Catheter, revealed "...catheter should be taped to the upper thigh to avoid tension on the catheter...physician's order for catheterization should include the reason for catheterization, frequency..." Interview with the resident in the resident's room on March 19, 2013, at 9:40 a.m., revealed the catheter was inserted soon after admission and the resident was not informed why it was needed or for how long it would be in. Continued interview revealed the resident stated "I want it out...I'm going to ask the doctor about it." Further interview revealed the resident stated the catheter was not anchored "to my leg" and "my foot gets caught in it sometimes." Continued interview revealed "it broke" and was leaking in the bed "about a week ago." The resident stated had occasional "leakage" in the past, but was able to toilet and did not have any issues with urge to urinate or incontinence. Interview with Licensed Practical Nurse (LPN) #	F 315		

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F 315	Continued From page 27 3, on March 21, 2013, at 7:43 a.m., in the nursing station, revealed "no policy" knows of for securing catheters, but secured them if it was "someone that pulls them." Interview on March 21, 2013, at 8:05 a.m., in the nursing station with Certified Nursing Assistant (CNA) #8, stated catheters are only secured "if resident pulls on them." Interview with the resident on March 21, 2013, at 10:00 a.m., in the resident's room, revealed the resident mentioned the catheter to the nurse yesterday and the catheter was removed; the resident had "gone to the bathroom" twice since then, and was glad to have it out. Interview with LPN #4 (MDS reviewer) on March 21, 2013, at 1:00 p.m., outside the Director of Nursing (DON) office, confirmed the resident did not have a diagnosis of neurogenic bladder, there was no documentation of medical justification for the indwelling catheter, and "I thought it should have been taken out last week." Interview with Quality Assurance Nurse on March 21, 2013, at 1:15 p.m., in the Director of Nursing office, confirmed the facility policy was to secure all catheters according to the facility policy. Resident #39 was admitted to the facility on January 30, 2013, with diagnoses including Insomnia, Constipation, Dementia, Nervousness, Anxiety, Agitation, Hypertension, Hallucination, Cystic Fibrosis, Amnesia, Gastritis, Vitamin B Deficiency, and History of Myocardial Infarction. Observations on March 19, 2013, at 10:00 a.m.,	F 315		

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F 315	Continued From page 28 and 3:15 p.m., March 20, 2013, at 9:00 a.m., and 2:00 p.m., and March 21, 2013, at 7:55 a.m., and 12:05p.m., revealed the resident in a Rock-and-Go wheelchair each time, with an indwelling catheter present and not secured. Interview with CNA #7 on March 21, 2013, at 7:10 a.m., in the nursing station, revealed catheters were secured with a clip for residents who pulled on them and only when they were in bed, but not in the wheelchairs. Interview with Quality Assurance Nurse on March 21, 2013, at 1:15 p.m., in the DON office, confirmed the facility policy was to secure all catheters according to the facility policy.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide supervision for one (#109) wandering resident of thirty-eight residents reviewed, and failed to ensure a safe environment by securing central supply room. The findings included:	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Resident #109 1) Will be monitored and redirected by all staff frequently. All Staff will be educated on the importance of maintaining other residents privacy by the Activities Director. 2) Known wanderers will be monitored by all staff and redirected more frequently to ensure that they remain within their allowed boundaries. Compliance started on 3/22/13. 3) Ongoing education of all staff will be completed by the ADON periodically to ensure that they are monitoring the residents effectively. Education log initiated. 4) QA Nurse to initiate an education log which will be kept and reviewed during the quarterly QA meetings. QA consists of the Administrator, Director of Nursing,	

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F 323	Continued From page 29 Resident #109 was admitted to the facility on April 13, 2010, with diagnoses including Fracture of Femur, Vascular Dementia with Depressed Mood, Anxiety, Anemia, and Hypertension. Medical record review of the quarterly Minimum Data Set dated January 23, 2013, revealed the resident had severe cognitive impairment, and behaviors of wandering requiring supervision. Observation on March 21, 2013, at 8:00 a.m., for twenty minutes, revealed resident #109 ambulating/wandering around the West nursing station and East & North Hallways. Further observation revealed the resident wandered into two resident rooms, 227 and 226, on the East hallway (both rooms are the last rooms on the far end of the hallway from the nursing station). Observation revealed no staff members were observed at the time the was resident going in and out of the resident rooms. Continued observation revealed the resident wandered down the hall and continued ambulating/wandering to the North hallway. Continued observation revealed the resident wandering in and out of resident rooms 240 and 248. A staff member (CNA # 4) was observed in the area of room 248 and no attempt was made to remove the resident. Continued observation revealed the resident ambulated/wandered in the hallway going back to the East hallway and in resident rooms 233, 227, 234, back to 227 and 234 without any interventions by staff. Interview with CNA # 4 on March 21, 2013, at 8:20 a.m., in the North hallway, confirmed the resident was observed ambulating/wandering in	F 323	Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1) Changing lock to a combination lock on Central Supply door for better security therefore eliminating the risk of potential elopement at the exit door. 2) Residents will not be able to access the Central Supply Room which will eliminate the elopement risk with the placement of the additional lock. Compliance met on 4/8/13. 3) Ensure that Property Manager verifies that the door is locked prior to his departure of the building. To be done on a daily basis. The Maintenance Director and Charge Nurse will assure that the door is locked during his absence. Safety Director educated all staff in the facility to ensure doors are locked. Will be in compliance by 5/5/13. 4) Supply person to maintain log weekly to monitor lock door. Maintenance to check security of Central Supply Door and both locks monthly. Log to be implemented and maintained by maintenance and to be presented at the quarterly QA meetings. QA committee will consist the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13 5/5/13

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F 323	Continued From page 30 and out of resident rooms. Further interview revealed, "the resident does ambulate in and out of resident rooms, but it is not a problem." Interview with the Minimum Data Set (MDS)/Care Plan Coordinators #1,#2 in the MDS office, on March 2013, at 9:00 a.m., confirmed both were aware of the resident's ambulating/wandering behavior. Further interview confirmed the resident was not being supervised when the resident was going in and out of other residents rooms. Observation of the facility on initial tour on March 18, 2013, at 7:30 p.m., revealed the door to the Central Supply office in the main hallway was unlocked and the door pushed open very easily. Inside the room were stored multiple containers of nasal sprays, Hydrogen Peroxide, nail clippers, batteries, chap stick, hand sanitizer, Miralax, Liquid Protein, Clorox wipes, UTI Stat, Normal Saline, and Oxygen canisters. Observation revealed at the back of the central supply room was an exit door to an outside, unsecured area, and the exit door was not locked and did not alarm. Observation on March 18, 2013, at 7:35 p.m., revealed Licensed Practical Nurse (LPN) #6 walked up to door, pushed the door and went in, without the key to enter the room. Interview with LPN #6 revealed "door is always unlocked after supply guy leaves for the day." Interview with the Quality Assurance Registered Nurse on March 18, 2013, at 10:41 p.m., in the central supply office, confirmed the door was not shut or locked, the facility did have elopement risk	F 323		

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F 323	Continued From page 31 residents and two residents who wander; and the unlocked room was not a safe environment.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure adequate monitoring of medications for one resident (#95) and failed to ensure gradual dose reductions were attempted as recommended for	F 329	F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1) PNS recommendations have been placed on chart and gradual dose reductions have been started and reviewed on resident's #95, #39, and #102 by the physicians. 2) All residents with PNS recommendations to be reviewed by physician for possible gradual dose reduction by 5/5/2013. 3) The QA Nurse to assure the pharmacist recommendations are either approved or denied by MD, noted and then placed on the charts. 10 charts will be audited monthly. Compliance met by 5/5/13. 4) Audit of monthly chart checks presented to the QA Committee on a quarterly basis. The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13 4/18/13

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F 329	Continued From page 32 two residents (#39, #102) of thirty-eight residents reviewed. The findings included: Resident #95 was admitted to the facility on March 19, 2012, with diagnoses including Hypertension, Depressed Mood, and Alzheimer's Disease. Medical record review of the Physician Recapitulation Orders for March 2013 revealed "...Seroquel (antipsychotic) ½ tab PO (by mouth) at bedtime..." Continued medical record review of the medication administration record revealed no documentation of monitoring of potential side effects of the antipsychotic. Observation in the secure unit on March 19, 2013 through March 21, 2013, revealed the resident in the common area dozing off at times. Interview with Licensed Practical Nurse (LPN) #1 on March 21, 2013,at 1:46 p.m., confirmed the facility failed to ensure risks, benefits, and signs and symptoms of unnecessary medications were monitored for resident #95. Resident #39 was admitted to the facility on December 21, 2009, and re-admitted to the facility on January 30, 2013, with diagnoses including Insomnia, Constipation, Dementia, Nervousness, Anxiety, Agitation, Hypertension, Hallucination, Cystic Fibrosis, Amnesia, Gastritis, Vitamin B Deficiency, and History of Myocardial Infarction. Medical record review of the Physician's	F 329	F 329 483.25 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1) Potential side effects of the antipsychotics on resident #95 documented on the MAR. 2) Review the MAR of the residents who are on psychotropic and antipsychotic medications to ensure side effects are documented and monitored by 5/5/2013. 3) Implement a form to be placed on the MAR per Pharmacy. Form will list the potential side effects of the particular antipsychotic medications for the particular resident. 10 charts will be audited monthly . 4) Form and Audit report will be presented quarterly at the QA meetings. The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13 4/18/13

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	860 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 recapitulation orders for March 2013, revealed the resident received Ativan (anti-anxiety medication) 0.5 mg (milligrams) twice daily and one tablet at bedtime as needed and Remeron (antidepressant) 15 mg at bedtime. Medical record review of the pharmacy Drug Regimen Review Flow Chart for August 14, 2012 through February 5, 2013, revealed the Consultant Pharmacist recommended on November 6, 2012, a gradual dose reduction for the Ativan and on January 8, 2013, a gradual dose reduction for the Remeron. Medical record review revealed no documentation a gradual dose reduction was attempted and no documentation for a medical contraindication to attempt gradual dose reductions. Resident #102 was admitted to the facility on September 7, 2012, with diagnoses including Hypertension, Congestive Heart Failure, Chronic Renal Failure, Hypothyroidism, Dementia, and Anemia. Medical record review of the Physician's Recapitulation Orders for March 2013, revealed the resident received Remeron 30 mg at bedtime, Seroquel (antipsychotic) 100 mg at bedtime and 50 mg at 2:00 p.m., and Ativan 0.5 mg three times daily. Medical record review of the Pharmacy Drug Regimen Review Flow Chart for September 10, 2012, through March 5, 2013, revealed the Consultant Pharmacist recommended on January 8, 2013, a gradual dose reduction for the Seroquel, on February 5, 2013, a gradual dose	F 329		

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F 329	Continued From page 34 reduction for the Ativan, and on March 5, 2013, a gradual dose reduction for the Remeron. Medical record review of a Pharmacy Recommendation Form dated January 2, 2013, revealed, "...Please consider (decrease) remeron to 15 mg at a trial GDR (gradual dose reduction)...Please consider (decrease) seroquel to 75 mg as a trial GDR..." Review of the recommendation revealed the Physician marked "No Action" and gave no reason for disagreeing with the recommendations. Medical record review of a Pharmacy Recommendation Form dated February 7, 2013, revealed, "...Please consider accepting previous GDR recommendations (mirtazipine [remeron] and Lorazepam [ativan])..." Review of the recommendation revealed no comment or signature from the Physician. Medical record review revealed no documentation a gradual dose reduction was attempted and no documentation for a medical contraindication to attempt gradual dose reductions. Interview with the Interim Administrator on March 21, 2013, at 2:30 p.m., in the conference room, confirmed there was no documentation of attempts at gradual dose reductions as recommended for residents #39 or #102.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1) Walk in refrigerator and ice machine were cleaned with 1:10 bleach solution. 2) Walk in refrigerator and ice machine will be monitored weekly by the Dietary Manager and	

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F 371	Continued From page 35 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide sanitary conditions in the food preparation and storage areas of the dietary department. The findings included: Observation of the walk-in refrigerator, during the initial tour of the kitchen, on March 18, 2013, at 7:40 p.m., revealed a black substance on the cooler fan and a small amount of a black substance on the refrigerator ceiling in front of the fan. Continued observation on the initial tour on March 18, 2013, at 7:44 p.m., revealed a greenish substance around the lid of the ice machine, and dripping down the front of the machine. Interview with the Dietary Manager on March 18, 2013, at 7:45 p.m., confirmed the black debris in the refrigerator, and the green substance around the lid and down the front of the ice machine.	F 371	cleaned monthly. Will be in compliance by 5/5/2013. 3) Monitor log initiated by Dietary manager. Dietary manager also implemented an auditing tool in order to maintain compliance. 4) Dietary Manager will report findings from log to the QA Committee which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 1) Potential side effects of the antipsychotics on resident #95 documented on the MAR. #95, #39 and #102 GDR has been reviewed and physician verbally notified of needed documentation of "No Action	

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F 428	Continued From page 36 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure pharmacy recommendations were acted upon timely for three residents (# 95, #39, #102) of thirty-eight residents reviewed. The findings included: Resident #95 was admitted to the facility on March 19, 2012, with diagnoses including Hypertension, Depressed Mood, and Alzheimer's Disease. Medical record review of a Pharmacy Consultation Report dated March 6, 2013, revealed, "...please consider discontinuing remeron (antidepressant) as a trial GDR (gradual dose reduction)..." Continued review of the Consultation Report revealed the Physician had not been notified of the pharmacy report. Interview with the Director of Nursing on March 21, 2013, at 8:02 a.m., in the Director's office confirmed that the facility failed to ensure the Pharmacy Consultation Report was acted upon.	F 428	Taken" on GDRs. Action taken on resident #102 following pharmacist GDR recommendations. 2) QA Nurse to review the MAR of the residents who are on psychotropic and antipsychotic medications to ensure side effects are documented and monitored. Ensure GDRs on residents are reviewed and properly documented by physician. This will be in compliance by 5/5/13. 3) Implement a form to be placed on the MAR by Pharmacy. Form will list the potential side effects and behavioral symptoms of the particular antipsychotic medications for the particular resident. Form will be monitored by the QA Nurse. 4) All pharmacy recommendations will be audited by the QA Nurse by 10 charts per month and presented to QA on a quarterly basis for a period of one year. The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	4/18/13

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F 428	Continued From page 37 Resident #39 was admitted to the facility on December 21, 2009, and re-admitted to the facility on January 30, 2013, with diagnoses including Insomnia, Constipation, Dementia, Nervousness, Anxiety, Agitation, Hypertension, Hallucination, Cystic Fibrosis, Amnesia, Gastritis, Vitamin B Deficiency, and History of Myocardial Infarction. Medical record review of the Physician's Recapitulation Orders for March 2013, revealed the resident received Ativan (anti-anxiety medication) 0.5 mg (milligrams) twice daily and one tablet at bedtime as needed, and Remeron (antidepressant) 15 mg at bedtime. Medical record review of the Pharmacy Drug Regimen Review Flow Chart for August 14, 2012, through February 5, 2013, revealed the Consultant Pharmacist recommended on November 6, 2012, a gradual dose reduction for the Ativan and on January 8, 2013, a gradual dose reduction for the Remeron. Medical record review revealed no documentation a gradual dose reduction was attempted, no documentation for a medical contraindication to attempt gradual dose reductions, and no acknowledgement the Physician was aware or followed up on the Pharmacy Recommendations. Resident #102 was admitted to the facility on September 7, 2012, with diagnoses including Hypertension, Congestive Heart Failure, Chronic Renal Failure, Hypothyroidism, Dementia, and Anemia. Medical record review of the Physician's	F 428		

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F 428	Continued From page 38 Recapitulation Orders for March 2013, revealed the resident received Remeron 30 mg at bedtime, Seroquel (antipsychotic) 100 mg at bedtime and 50 mg at 2:00 p.m., and Ativan 0.5 mg three times daily. Medical record review of the Pharmacy Drug Regimen Review Flow Chart for September 10, 2012, through March 5, 2013, revealed the Consultant Pharmacist recommended on January 8, 2013, a gradual dose reduction for the Seroquel, on February 5, 2013, a gradual dose reduction for the Ativan, and on March 5, 2013, a gradual dose reduction for the Remeron. Medical record review of a Pharmacy Recommendation form dated January 2, 2013, revealed, "...Please consider (decrease) remeron to 15 mg at a trial GDR (gradual dose reduction)...Please consider (decrease) seroquel to 75 mg as a trial GDR..." Review of the recommendation revealed the Physician marked "No Action" and gave no reason for disagreeing with the recommendations. Medical record review of a Pharmacy Recommendation Form dated February 7, 2013, revealed, "...Please consider accepting previous GDR recommendations (mirtazipine [remeron] and Lorazepam [ativan])..." Review of the recommendation revealed no comment or signature from the Physician. Medical record review revealed no documentation a gradual dose reduction was attempted, no documentation for a medical contraindication to attempt gradual dose reductions, and no acknowledgement the Physician was aware or	F 428		

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CENTER ON AGING AND HEALTH	650 SOUTH MOHAWK DRIVE ERWIN, TN 37650

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F 428	Continued From page 39 followed up on all of the Pharmacy Recommendations. Interview with the Interim Administrator on March 21, 2013, at 2:30 p.m., in the conference room, confirmed the facility had no process to ensure Pharmacy Recommendations were acted upon by the physicians.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) Proper hand hygiene will be maintained at all times. Facility will be in compliance Immediately 2) Handwashing policy reviewed. Provided handwashing hygiene to staff. Also, added hand sanitizers to each medicine cart. Educated medicine nurses to utilize medication cups during med pass. Continue to do staff education regarding hand hygiene. 3) Random monitoring conducted on Center's rounding log to track compliance which is completed Monday through Friday periodically by the management team. 4) Present rounding log to the QA Committee on a quarterly basis for a period of one year. The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13 6/18/13

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F 441	Continued From page 40 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote standard infection control practices. The findings included: Observation of Licensed Practical Nurse (LPN) #1 on March 18, 2013, at 8:42 p.m., on the 200 hallway, revealed Charge Nurse #1 administering medications. Continued review revealed the LPN placed a medication into a resident's bare hand and failed to wash the hand prior to placement. Interview with the LPN on March 18, 2013, at 8:44 p.m., on the 200 hall, confirmed the LPN failed to maintain infection control for the resident by not washing the hand and/or leaving medication in a medication cup. Observation on the secure unit on March 21, 2013, at 1:02 p.m., with the Director of Nursing, revealed the following in the secure unit shower room: two bars of hand soap not labeled and available for use, two hair brushes and one comb with various colors of hair not labeled and	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) The Safety Director will continue to review and revise Infection Control Program identifying immediate deficiencies in infection control. 2) Increase awareness to staff regarding infection prevention methods with standard precautions. To be in compliance by 5/5/13. 3) QA Nurse will monitor and track infections throughout the facility on a monthly basis by antibiotic usage, labs, chest x-ray and identify micro-organisms which indicate need for isolation precautions. 4) Report types of infections, specific micro-organisms and any trends during the quarterly QA meeting. The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) All of the personal hygiene items labeled with residents name in Room 418 for proper identification. 2) Review all personal hygiene items in each room to ensure each resident has a proper label. Compliance to be maintained by 5/5/13. 3) Routine checks on personal hygiene to be checked at scheduled shower times by CNA's to ensure the items are properly labeled for each	5/5/13 5/5/13

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F 441	Continued From page 41 available for use, two curling irons with various colors of hair not labeled and available for use,BM on the floor, and clean briefs in a plastic bag next to bowel movement. Continued review of the secure unit revealed room 418 with two tubes of toothpaste, one tube of fixadent not labeled, and available for use. Interview with the Director of Nursing on March 21, 2013, at 1:14 p.m., confirmed the facility failed to maintain infection control. Observation on March 21, 2013, at 2:02 p.m., revealed Certified Nursing Assistant #8 carrying an open plastic bag next to the body with clean linens inside. Interview with the Environmental Director on March 21, 2013, at 2:03 p.m., confirmed clean linens should not be transported close to the body and clean linen carts are available for transport of linens. Resident #39 was re-admitted to the facility on January 30, 2013, with diagnoses including Dementia, Nervousness, Hallucinations, and Hypertension. Observation was made on March 20, 2013, at 2:20 p.m., in the resident's room, of a dressing change, to a wound on the resident's coccyx, revealed the resident confused and lying in bed, positioned to the left side. Further observation revealed a urinary catheter was in use for the resident with the urine collection bag (contained in a privacy bag), lying on the floor at the resident's bedside. Continued observation	F 441	individual resident. CNAs are also to stock personal hygiene items as needed. CNA Mentor will maintain a log. 4) Conduct a QA on personal hygiene items and report findings during the quarterly QA meeting. QA consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) Special Care Shower Room cleaned and all personal items were sanitized and labeled. Individual bins have been labeled with resident's names and designated for each Special Care Resident's personal hygiene items. CNA'S have been instructed to clean the shower room between each shower with 1:10 bleach solution. 2) Ensure CNA's are using personalized bins for each resident and educate staff members of the importance of infection control by not placing clean linens or briefs in the floor or near soiled areas by 5/5/2013. 3) Checklist to be monitored by the Charge Nurse and/or CNA Mentor for cleaning of shower room between each resident on specified shower list chart. Also, Charge Nurse and/or CNA Mentor to perform random checks during shower times to ensure that each resident's items are being individualized to prevent spread of any infection.	5/5/13

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F 441	Continued From page 42 revealed when the dressing change was completed the resident was repositioned for comfort but staff failed to properly position the urinary catheter collection bag (off of the floor) prior to exiting the resident's room. Interview with Licensed Practical Nurse #5 (LPN) at the time of the observation, confirmed the urine collection bag was improperly placed to prevent urinary stasis and reduce the potential risk of urinary tract infection. Interview with the Assistant Director of Nursing (ADON) , on March 21, 2013, at 7:30 a.m., in the Director of Nursing's office, confirmed a urinary catheter collection bag was incorrectly positioned for optimal urine drainage and collection if lying flat on the floor. Continued interview confirmed this was not according to recognized standards of practice for a urinary catheter, and posed and increased risk of potential urinary tract infection for the resident. Observation of the west wing central shower on March 20, 2013, at 9:35a.m., revealed a privacy curtain with multiple stains of varying colors from black to deep red. Environmental inspection of the shower room revealed ceiling paint peeling at vent, zip tie holding light cover on in left side shower, privacy curtain dirty. Certified Nursing Assistant (CNA) #4 confirmed the zip tie and the peeling had been present for about a year, since she had started working here. Interview with the Director of Nursing (DON) on March 21, 2013, at 9:50 a.m., confirmed the zip tie on the light, the peeling paint on the ceiling	F 441	4) Charge Nurse or CNA Mentor to present Audit to QA Committee quarterly. QA consists of Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads. F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) Resident #39 indwelling catheter was placed in a privacy bag and properly positioned off the floor for adequate drainage of urine flow March 20, 2013. 2) Review all residents with indwelling catheters and assess containment in a privacy bag and properly positioned off the floor for adequate drainage of urine flow by April 15, 2013. 3) ADON to educate all Nursing and CNA staff as well as all Administrative staff regarding proper storage of indwelling catheters in a privacy bag and catheters to be off the floor and positioned for adequate drainage. QI will be measured with random checks within rounding process that is done by the Rounding Leadership Team consisting of the Director of Nursing, Assistant Director of Nursing Safety Director, Business Office Manager, Social Services Director, and Admissions Coordinator. Indwelling catheters to be monitored on rounding sheets. 4) Findings of QI reported quarterly to the QA Committee for a period of one year. QA consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

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F 441	Continued From page 43 and the dirty curtain, stated it "looks like blood". and stated curtains are to be cleaned monthly. Review of the Infection Control Program, Infection Control Policies and Procedures, and interview with the Coordinator of Infection Control (ICC) on March 20, 2013, at 1:35 p.m., in the Training Room, revealed the Infection Control Coordinator had recently implemented an infection control program for surveillance and tracking of infections in November 2012; implemented an education program for staff regarding hand hygiene, safety, isolation precautions, and universal precautions conducted by the Director of Housekeeping and Environmental Services within the last month; and had implemented a rounding program to ensure hand hygiene was performed correctly by staff in the past week. Further interview revealed the ICC was unaware of any policies and procedures, education programs, or surveillance and monitoring programs in place prior to November 2012. Further interview confirmed the infection control program was still being developed and was not fully implemented currently and did not include monitoring of lab reports for correct antibiotic usage; monitoring and tracking of specific organisms; and monitoring and surveillance for placing residents in isolation. Further interview confirmed the facility did not have adequate policies and procedures in place for a complete Infection Control Program.	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) The West Wing central shower ceiling has been painted. The zip-tie has been removed from the light cover and has been fixed appropriately. 2) There will be routine monthly maintenance and as needed checks on all shower rooms, walls, ceilings and light fixtures. Compliance to be met by 5/5/13. 3) The shower rooms are to be inspected quarterly by maintenance and logged into a tracking log specifically for the shower rooms. 4) Maintenance will submit the tracking log to QA meetings ongoing. QA consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520	F520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 1) QA Nurse to review current deficiencies and tracking of restraints/safety measures, infection control log, monitoring of weights and process for	

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F 520	Continued From page 44 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, and interviews the facility failed to ensure the Quality Assurance Committee consistently developed and implemented plans for improved resident care and safety (particularly related to infection control, resident safety and restraints, and pharmacist reviews). The findings included: Review of the facility policy Quality Assessment Performance Improvement Plan (undated) revealed "...A. 2. Facilitate...day to day operations	F 520	physician review of pharmacy reviews/recommendations. 2) QA Nurse to review all residents with restraint devices for completion of assessments/documentation, physician orders, review residents on current antibiotics and review labs for specific micro-organisms and update tracking log and continue with accident/incident tracking log and placing investigation with interventions on care plan. Ensure that all Pharmacy Review/Recommendations have been placed on charts and addressed by the Physician by 5/5/13. 3) QA Nurse to continue to track log of accidents/incidents and will place intervention copy on the care plan. Also QA Nurse will track log of infection including micro-organisms identified, and conduct a QI on pharmacy review with follow-up by physicians to include reason for "No Action". 4) Report quarterly and trend accidents/incidents, infection log and trends, compliance of weight monitoring, compliance of pharmacy review/ recommendations signed by the physician to QA Committee. QA consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Safety Director and Department Heads.	5/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

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F 520	Continued From page 45 based on results of measured Quality of service and patient care...B. 4. (d) To review and analyze collected data and indicators and recommend corrective action...3. (Infection Control) An infection control checklist will be completed monthly as an ongoing examination of the Center's standards. 4. (Safety) At least quarterly, the Administrator and/or designee will complete a review of the safety program. 5. (Patient Falls) The facility will collect data and investigate falls on a monthly basis...6. (Pharmacist Review) The consulting pharmacist will perform an on-site review...Should there be any problem areas or discrepancies, the Quality Assessment and Performance Improvement Committee will create a plan of corrective action and follow-up..." Review of requested investigative documentation related to identified resident care concerns March 18 through March 21, 2013, revealed absent documentation and informational gaps were identified in the areas of weight monitoring, accident investigations, infection control monitoring, and pharmacy recommendations being processed timely. Interview with the Administrator (NHA) and Director of Nursing (DON) on March 19, 2013, at 7:15 a.m., outside the DON's office revealed the facility had experienced a high turn-over in the administrative positions in recent months. Continued interview revealed the NHA and DON had both held their positions for a relatively short amount of time, and attributed the informational gaps and lack of documentation to the administrative inconsistencies. Interview with the Quality Assurance (QA)	F 520		

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F 520	Continued From page 46 Chairperson, on March 21, 2013, at 1:30 p.m., in the training room, revealed the Chairperson had been recently employed by the facility. Continued interview confirmed, the QA systems were now in place, but evidence and/or documentation of consistent Quality of Care initiatives and monitoring could not be produced for the specified look back period (since the last survey). Monthly Infection Control Tracking/Trending logs, consistent and accurate resident weight monitoring, and Safety/Falls Reviews could not be consistently produced to ensure sufficient quality monitoring. Interview with the QA Chairperson confirmed the documentation was lacking, informational lapses were present, and the facility QA policy had not been followed.	F 520		